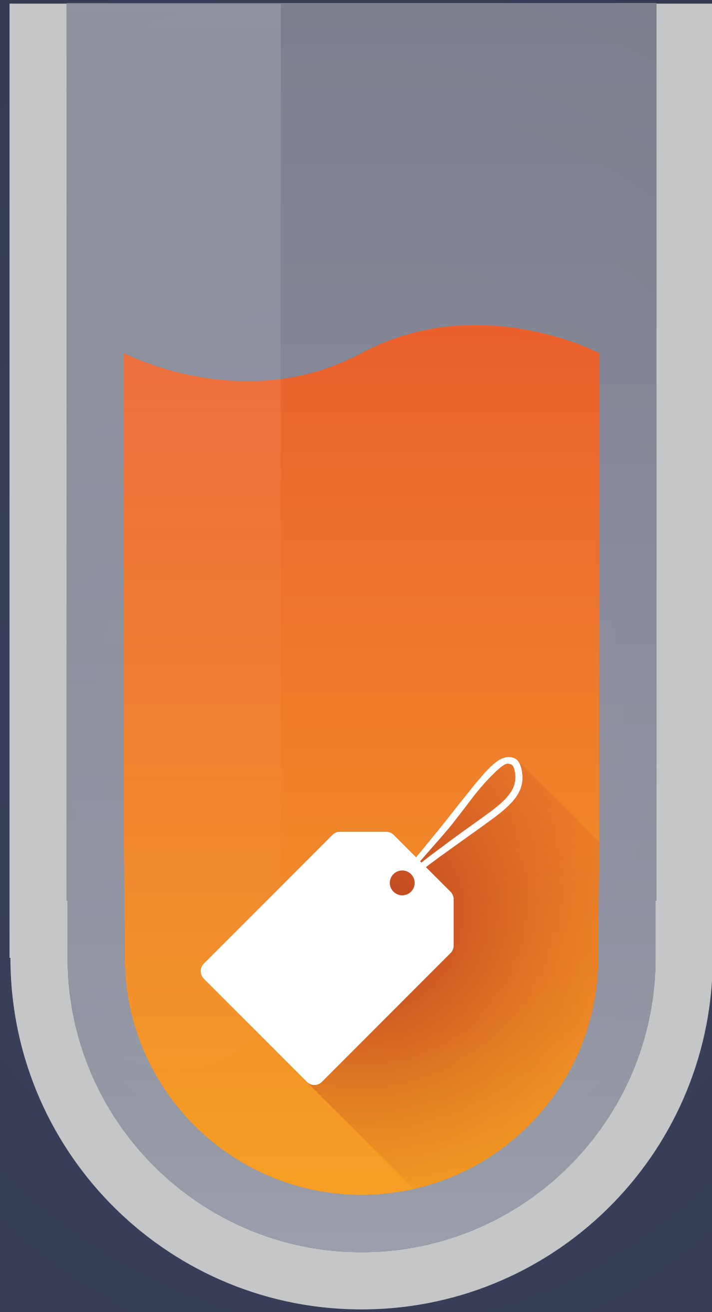


Drug Sticker Shock

Can your patient pay for a medication? Many doctors still don't ask the question

By Delia O'Hara

NEWSPAPERS and the Internet have been full of stories lately about the high cost of prescription drugs, but it can be an abstraction to your patient until she's standing at the pharmacy counter at her local drugstore hearing the bad news: She'll need to pay $75 out of pocket for one month's supply of that daily corticosteroid inhaler you prescribed, even after her insurance has paid the bulk of the cost.

That's $900 to treat her asthma for one year. What will she do? She might decide she can't afford the new treatment; maybe she'll just depend on her trusted Albuterol inhaler when things get bad. She might turn away and go home without that daily inhaler, or she might buy it and use it only occasionally. You might not find out she's not using the treatment you prescribed the way you intended until she comes to see you for her wellness visit a whole year later, and then only if she 'fesses up.

But here's the question: Did you talk with your patient when she was in your office about how much the new inhaler would cost? Only about 12% of physicians did in a study published in 2006, and one influential family physician said he thinks many doctors still aren't having that conversation.

Half of all Americans take at least one prescription drug, but as the late C. Everett Koop, former U.S. Surgeon General, famously put it, "Drugs don't work in patients who don't take them." The role of drug cost in patients' adherence to their treatment plans is unclear. In different studies, cost accounted for 11 to 55% of non-adherence, which accounts for upwards of $100 to $300 billion in avoidable healthcare outlays. Non-adherence is responsible for up to half of treatment failures, and results in an estimated 125,000 deaths annually, all according to a 2014 report from the U.S. Centers for Disease Control and Prevention (CDC).

But the money patients and their insurers lay out on drugs is definitely going up. Retail prescription drug spending accelerated in 2014, growing 12.2% that year alone, to $297.7 billion, according to the Centers for Medicare & Medicaid Services. New specialty drugs, including effective but expensive new treatments for hepatitis C, accounted for much of the increase. Private health insurance, Medicare, and Medicaid all paid out more on drugs in 2014.

Is the Cost Justified?

BRAND-NAME drug prices frequently rise, often dramatically, over time, and the reasons for the increases are not always clear. For example, one drug, imatinib, a tyrosine kinase inhibitor manufactured by Novartis as Gleevec has been extremely effective in treating chronic myeloid leukemia, but cost nearly $30,000 per year when it was released in 2001. By 2012, that price had risen to $92,000, according to an article critical of escalating cancer-drug prices published in 2013 in *Blood*, the journal of the American Society of Hematology, which was signed by 100 cancer specialists from all over the world.

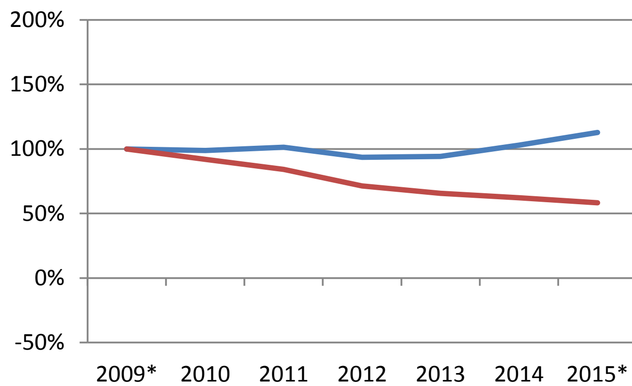
And this was true, the authors said, despite the fact that: 1) all research costs were accounted for in the original proposed price—and therefore increases were not needed to recoup costs; 2) new indications were developed and FDA approved—meaning that many more potential consumers now exist than when the drug was first approved—and, therefore, the prevalence of the CML population continuing to take imatinib was dramatically increasing, taking revenue upward with it.

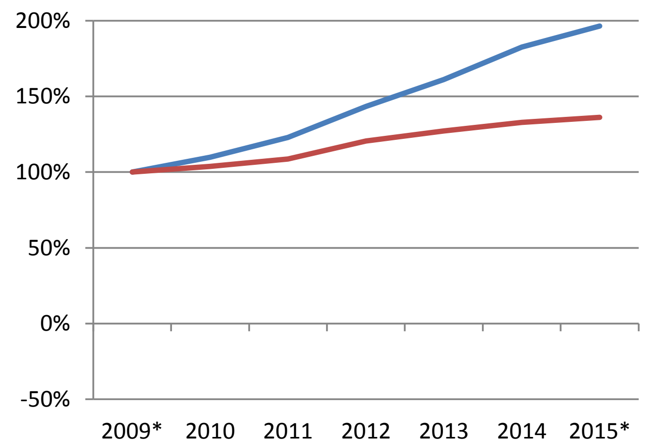
Novartis recently emailed a response to *Chicago Medicine* that said in part: "The ability to adjust prices during the limited period of market exclusivity ensures that we continuously reflect the value of the treatment, based on an evolving healthcare and competitive environment and the availability of new scientific evidence.

Price adjustments also support future innovation through reinvestment in research and enable the recovery of [research and development] costs, which for oncology medicine continue throughout and beyond the end of patent life."

Leigh Purvis, director of health services research for the AARP Public Policy Institute, said in an interview that "there is nothing in the system to stop these increases from happening" with any pharmaceutical company. Purvis called for better transparency about "how these prices are set," and said her group is "working to get some of those answers." In some other countries, drug companies must provide an "effectiveness assessment" that shows how a new medication compares with existing treatments. "If they're providing that information to other countries, they can provide it to us, too," she said.

Gleevec emerged from patent protection in January, and a study in the *Journal of the National Cancer Institute* estimated that the cost of treating CML could fall as much as 90% when generic equivalents become fully available in the United States toward the end of this year, or early in 2017.





Retail Revenues — Retail Prescription Units

And prices went up sharply again in 2015, IMS Health, Inc., a health-information and technology firm, reported.

Simple, Straightforward Communication

John Hickner, MD, a professor of family medicine at the University of Illinois at Chicago, said there is a lot of "profiteering" going on in drug pricing right now, and he called on the federal government to take steps to constrain costs. Meanwhile, Dr. Hickner said, physicians can take the "simple step of asking, 'Can you afford your medications?' If cost is a factor, [a physician can] look into a less expensive substitute medication, or use one of the prescription-support programs. (See "Resources" sidebar.) Look at nonpharmacological options, too. We regularly work with our patients on lifestyle changes."

Adrienne Fregia, MD, president of the Chicago Medical Society, said she always discusses cost with her patients, who "run the gamut from

Resources

NUMEROUS SITES exist to help you and your patients stay abreast of changing drug prices. Be sure to bookmark them and pass them along to patients who must purchase expensive medications:

goodrx.com is a site that compares drug prices among a number of chain and local providers.

Consumer Reports Best Buy Drugs is a free report.

National Conference of State Legislatures **Resources on Pharmaceutical Costs and Access** is an exhaustive list of reports, updates, and consumer-assistance programs.

2014 **healthline.com** article compares a number of patient-assistance programs. The article is about defraying the cost of insulin, but has a wealth of information for any patient or provider.

The prescription assistance page at **healthfinder.gov** has links to a number of sites; Healthfinder is a great resource on any health topic.

Benefits Check Up, a service of the National Council on Aging, helps people find assistance with paying for prescription drugs—and food.

Extra Help with Medicare Prescription Drug Plan Costs is a government site where Medicare recipients with limited income can begin to apply for help.

Medicare Access for Patients Rx (MAPRx) is a non-government site that helps Medicare recipients navigate the prescription drug program.

National Cancer Institute's list is 100 organizations that provide assistance, including financial help, to cancer patients.

State Health Insurance Assistance Program (SHIP) counsels people on health issues having to do with Medicare and the Affordable Care Act.

Uninsured patients can get started on finding coverage at the website of the **U.S. Dept. of Health & Human Services**.

U.S. Food and Drug Administration's "**Resources for You (Drugs)**" portal, features pages for both physicians and patients containing non-price updates.

upper-class to low-income. The cost of drugs is affecting all ranges." She finds that patients often want advice on how they can save money, but they'll also change the way they take their medications on their own, taking perhaps only "25% of what is prescribed, [and] lots of patients will admit to taking their children's or their spouse's medications," said Dr. Fregia, a gastroenterologist who practices in the south suburbs of Chicago.

Straightforward communication with their doctors helps patients begin strategizing to find a treatment they can live with, Dr. Fregia said. Physicians who speak and write about adherence and patient-centered practices agree that physicians also need to remember that the most expensive drug is not necessarily the best one.

Marie Brown, MD, points to metformin, the inexpensive first-line drug for type 2 diabetes. In terms of effectiveness, "it stands alone," she says, and it costs "pennies" a pill. However, at each new dose, metformin frequently causes diarrhea for a few days. "It always goes away," Dr. Marie Brown said, but patients may not know that, and their doctors may not work with them to manage this temporary but disconcerting problem. The patient may ask for a different treatment—or, he may simply stop taking the metformin without letting his doctor know. If the physician reaches for that second-line drug, Dr. Marie Brown said, she is by definition moving away from the best treatment out there for diabetes—and into the realm of more expensive drugs. "My patients can't afford those second- and third-line drugs," Dr. Marie Brown said. She advises doctors to "make sure the patient is taking the first-line drug as prescribed," and help them deal with short-term side effects.

Shiny New vs. Old Workhorse

But physicians aren't trained to appreciate those workhorse older drugs, said Steven Brown, MD, a Phoenix, Ariz., family physician and a contributing editor to *American Family Physician,* with an interest in patient-centered medicine, and a proponent of what he calls "high-value prescribing." Some drugs—including some very expensive new drugs—are so effective there is no way around using them for optimal results, Dr. Steven Brown said. Then a physician's role might be to help patients find a way to pay for them. He employs a social worker in his own office to do just that. Medicines used correctly can head off other health care costs, he said.

But Dr. Steven Brown still advises prescribing conservatively, including considering

The High Cost of Drugs in the U.S. Compared to Other Countries

Drug (Cost per month)	**Canada**	**UK**	**Spain**	**Netherlands**	**Switzerland**	**U.S.**
Enbrel (autoimmune)	$1,646	$1,117	$1,386	$1,509	$1,017	$3,000
Celebrex (pain)	$51	$112	$164	$112	$138	$330
Copaxone (MS)	$1,400	$862	$1,191	$1,190	$1,357	$3,900
Cymbalta (depression)	$110	$46	$71	$52	$76	$240
Gleevec (leukemia)	$1,141	$2,697	$3,348	$3,321	$3,633	$8,500
Humira (arthritis)	$1,950	$1,102	$1,498	$1,498	$881	$3,049
Nexium (acid reflux)	$30	$42	$58	$23	$60	$305

Drug prices in the U.S. are up to 10 times higher than in numerous other developed countries. U.S. average prices are calculated using commercial claims data from Truven MarketScan Research databases. Source: The International Federation of Health Plans (IFHP) 2013 Comparative Price Report.

Most Americans Favor Action to Keep Drug Prices Down

Percentage who say they support each of the following in keeping prescription drug costs down:

Source: Kaiser Family Foundation Health Tracking Poll (conducted Aug. 6-11, 2015)

nonpharmacological treatments before even thinking about drugs. However, he said, "traditional medical education focuses on the fascination of the 'tech' and the new, rather than on the fidelity of the system, on what we know works for everybody," Dr. Steven Brown said.

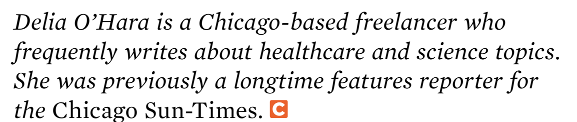
Not only that, but "research is biased toward medical interventions like drugs and devices...We have to approach [treatment] in a patient-centered way," said Dr. Steven Brown. That means considering what will work for a particular patient, and taking the cost of drugs and devices into account.

The bias toward expensive interventions—the tech and the new—is exacerbated by the longstanding relationship between physicians and pharmaceutical companies, which, despite years of criticism, is still going strong. A 2009 survey of nearly 3,000 randomly selected physicians showed that 84% of them had a relationship with at least one drug company; that number had decreased from 94% in 2004, but it's still high.

"It doesn't pass the simple test of: "Is this the right thing to do?" said Dr. Steven Brown. He called it "a conflict of interest," and said that "consumers should be upset about it." Dr. Steven Brown said that while "billions of dollars are spent on rep visits and gifts to doctors," the "bigger problem" is that physicians "are accepting of marketing from the industry," and of "continuing medical education funded by pharmaceutical companies." Doctors don't bring "the skepticism it deserves" to the larger message from the industry, that the shiny new drugs are the only game worth playing, he said.

Are You Putting Patient Preferences First?

Physicians need to get a sense of which medications are cost-effective, which ones actually work for most people, for every common condition they see, said Dr. Steven Brown. They "have to ask every patient, 'Do you have trouble paying for your meds?'—and most don't. Not even close. They're not considering the patient-centered approach to care. Their training doesn't put patient preferences first."



Delia O'Hara is a Chicago-based freelancer who frequently writes about healthcare and science topics. She was previously a longtime features reporter for the Chicago Sun-Times.

Tips for High-Value Prescribing

THE CONCEPT of "high-value prescribing" may mean prescribing a costly drug only as a last resort, according an editorial by Steven R. Brown, MD, in *American Family Physician* earlier this year. Dr. Brown suggests physicians follow these guidelines:

- Be skeptical about brand-new drugs. "Very few are novel and useful in primary care," Dr. Brown writes.
- Know the STEPS—the Safety, Tolerability, Effectiveness, Price and Simplicity of a drug—before prescribing a medication.
- Get familiar with drug prices. This is crucial for using STEPS. One source is the website goodrx.com.
- Is there a generic equivalent? When they're available, they are as effective as brand-name drugs, typically at a fraction of the cost.
- Reduce the access you allow pharmaceutical representatives to you, your office and your staff. Too cozy a relationship and the "use of [drug] samples lead to higher medication costs—both out of pocket and total—and irrational prescribing," Dr. Brown writes.
- Prescribe conservatively. "Think beyond drugs," if you can, Dr. Brown writes, to develop a strategy for addressing your patients' individual health needs.
- Learn to use a few drugs well, and stay on top of your patients' experience with them.